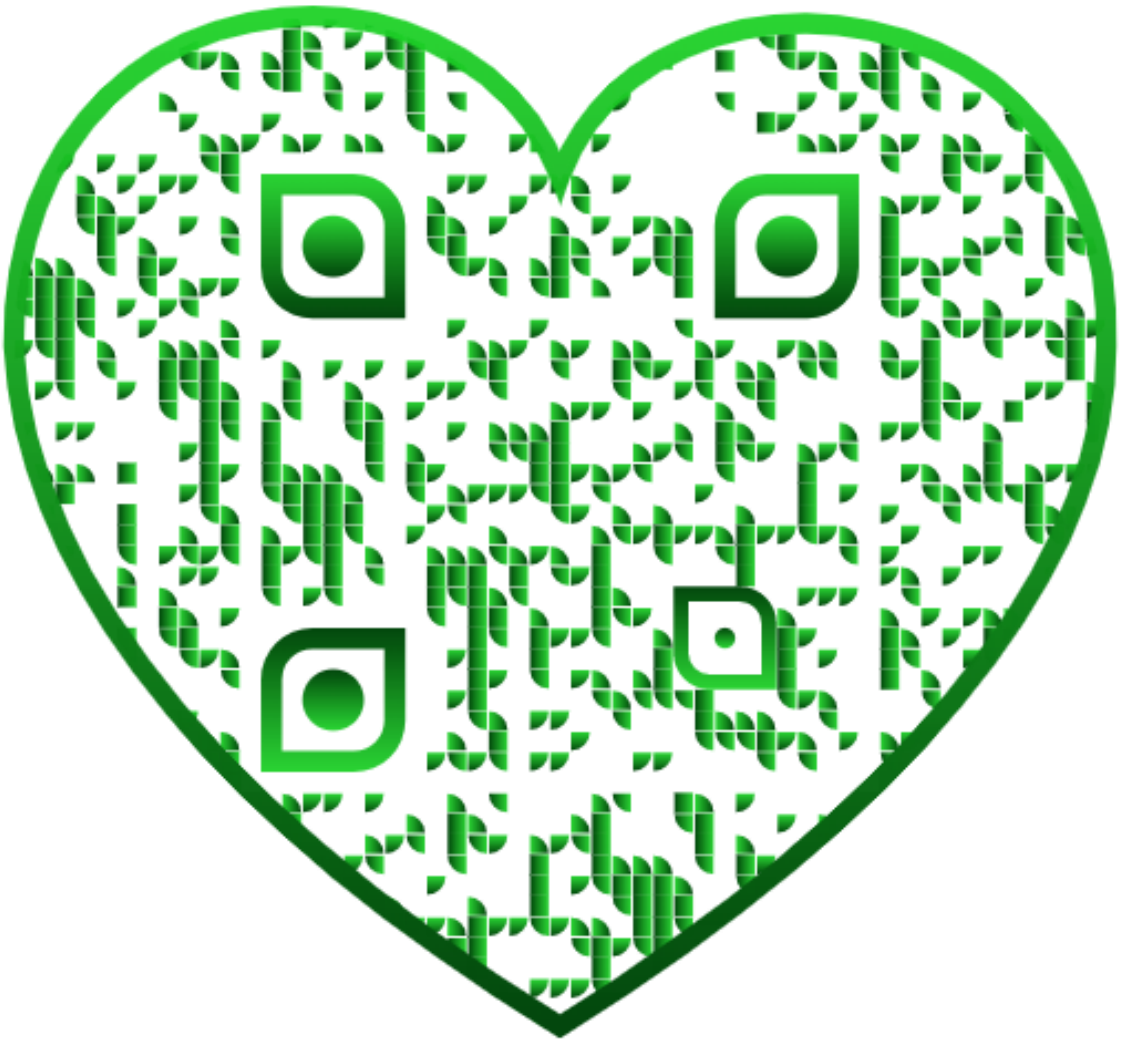
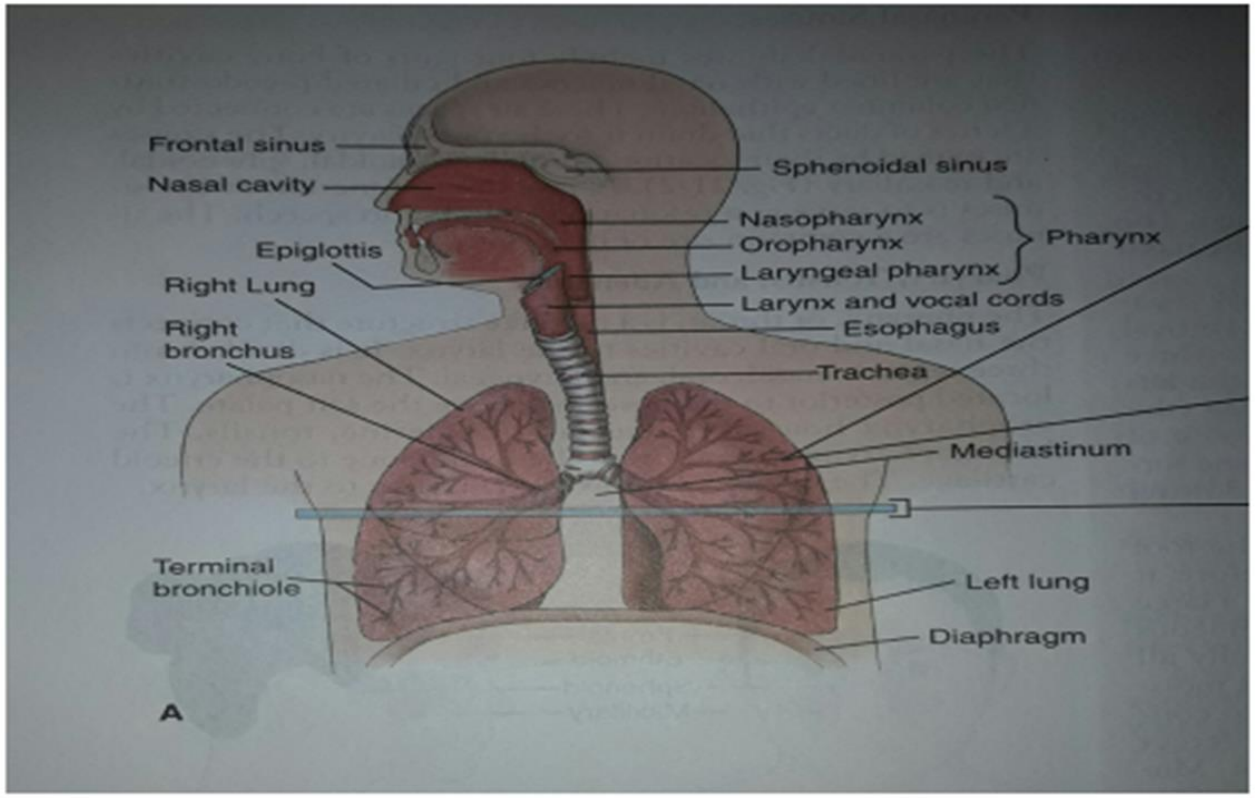
Chest Examination

Chest examination includes:

- **Assessment of respiratory system**
- **Cardiac assessment**



Respiratory examination



Cont'd

Techniques of respiratory assessment:

- **Inspection**
- **Palpation**
- **Percussion**
- **Auscultation**

Cont’d

Techniques of cardiac assessment:

- **Inspection**
- **Palpation**
- **Auscultation**

Cont'd

Chest inspection to detect any:

- **Altered chest configuration like**
  - **Pigeon chest**
  - **Barrel chest**
  - **Prominent left anterior chest**
- **Change in respiratory patterns**
  - **Respiratory distress**
  - **Respiratory rate**
  - **Respiratory rhythm**

Cont'd

Chest palpation to detect any:

- **Tenderness**
- **Mass**
- **Tracheal deviation**
- **Tactile fremitus**

Cont'd

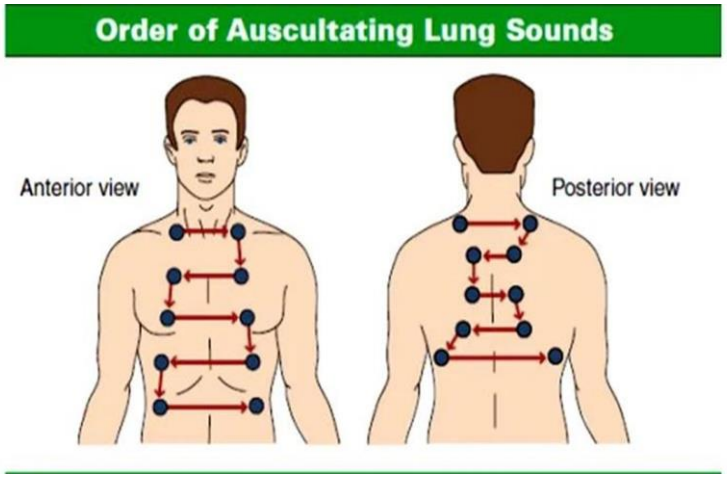
Chest percussion to help to elicit sound:

- **To help to rule out abnormalities like**
  - **Pneumothorax**
  - **Pleural effusion**
  - **COPD**
  - **Mass**

Cont'd

Chest auscultation to help to detect:

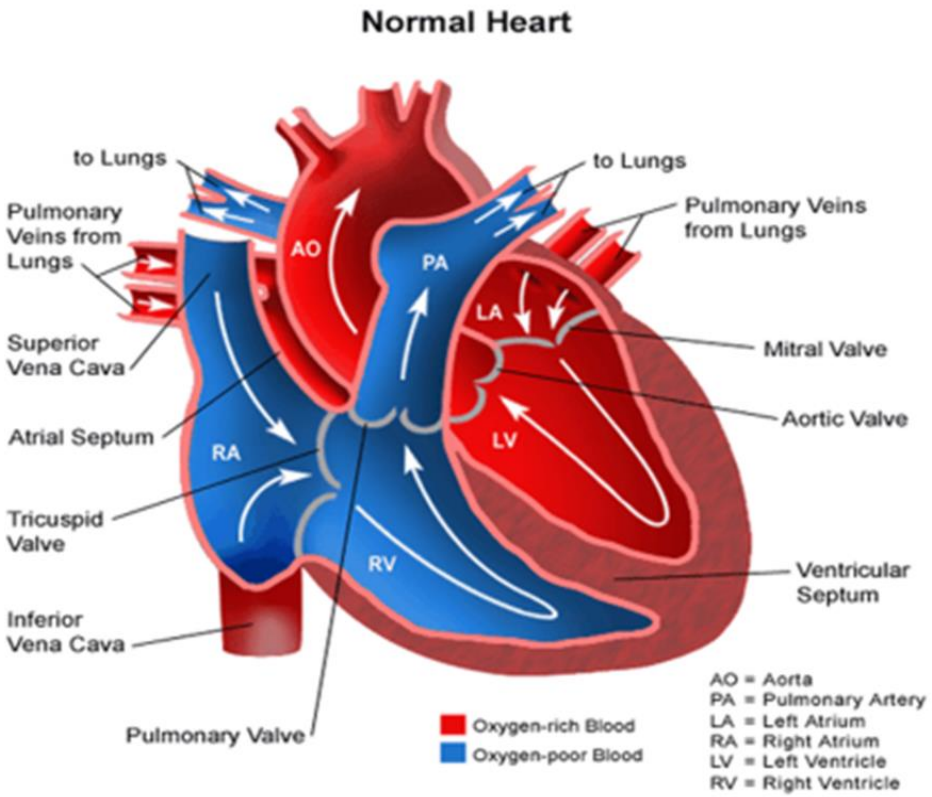
- **Any abnormal breath sound**
  - ✓ **Like Wheezing, Strider, Decreased breath sound etc.**



Cont'd

- **Measurement of arterial oxygen saturation**
  - **To detect hypoxia or hypoxemia**
  - **Normal: 95-100%**
  - **Instrument: Pulse oximetry**

Cardiac examination



Cont'd

- **Inspection for**
  - **Chest deformity**
    - ✓ **Building or depression**
  - **Palpitation**
  - **Pulse point etc.**

Cont'd

- **Palpation for**
  - **Peripheral pulse assessment**
  - **Thrill**
  - **Heave**

Cont'd

- **Auscultation for**
  - **Heart sound**
    - ✓ **First heart sound**
    - ✓ **Second heart sound**

Abdominal Assessment

- **Techniques:**
  - **Inspection**
  - **Auscultation**
  - **Palpation**
  - **Percussion**

Cont’d

Cont'd

- **Inspect abdomen of a client for:**
  - **Protuberance (small bulging)**
  - **Marked protuberance (distention)**
  - **Localized bulging**
  - **Any ulcer**

Cont'd

- **Gross distension (5 F)**
  - **Fluid**
  - **Flatus**
  - **Feces**
  - **Fetus**
  - **Fat**
- **Localized distension**
  - **Loculated fluid**
  - **Mass**
  - **Hernia**
  - **Organomegaly**
  - **Impacted feces**

Cont'd

- **Auscultation for bowel sound**
  - **Norm-active**
  - **Hyperactive: Intestinal obstruction, Diarrhea**
  - **Hypoactive : Paralytic illus or peritonitis**

Cont’d

- **Abdominal palpation for:**
  - **Any tenderness**
  - **Abdominal mass**
  - **Organ enlargement**

Cont'd

- **Abdominal percussion for:**
  - **Bowel sound related finding like**
    - ✓ **Mass**
    - ✓ **Fluid accumulation**

Genito-Urinary Examination

- **TECHNIQUES**
  - **Inspection**
  - **Palpation**

Genito-Urinary Examination

- **Inspection for any**
  - **Genital ulcer**
  - **Supra-pubic swelling**
  - **Discharge**

Genito-Urinary Examination

- **Palpate for any**
  - **Tenderness**
  - **Mass**
  - **Discharge**

Musculoskeletal examination

- **Techniques**
  - **Inspection**
  - **Palpation**

Musculoskeletal examination

- **Inspection for**
  - **Bilateral growth of extremities**
  - **Swelling (localized) as in;**
  - **Deformity**
  - **Mass**
  - **Fracture**

Musculoskeletal examination

- **Palpation**
  - **Any tenderness**
  - **To check for cracking**
  - **Mass**

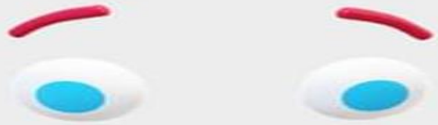
Nerves System examination

- **Techniques**
  - **Inspection**
  - **Palpation**
  - **Percussion**

Cont'd

- **Examination of the nervous system includes:**
  - ✓ **Mental status**
  - ✓ **Meningeal irritation signs assessment**
  - ✓ **Sensation**

Mental status examination

Behaviour	Response
 **Eye Opening Response**	4. Spontaneously 3. To speech 2. To pain 1. No response
Verbal Response	5. Oriented to time, person and place 4. Confused, but able to answer Qs 3. Inappropriate words 2. Incomprehensible sounds 1. No response
Motor Response	6. Obeys commands 5. Moves to localised pain 4. Flex to withdraw from pain 3. Abnormal flexion, decorticate posture 2. Abnormal extension, decerebrate posture 1. No response
Minor Brain Injury = 13-15; **Moderate Brain injury** = 9-12; **Severe Brain Injury** = 3-8 Record the GCS as a total and its tree sperate components: e.g., GCS 8/15: E3, V2, M3	

Cont'd

- **Case scenario:**

A 27 yrs old male patient has presented to a clinic with history of falling accident 1.5hrs ago. Physical examination has revealed abnormal upper limb flexion & eye opening to pain stimuli with inappropriate response

Assess client for signs of meningeal irritation

- **Neck stiffness**
- **Kerning's sign**
- **Brudzinski's sign**

Cont'd

a. Neck stiffness

- Ask a client to flex his neck and touch his sternum with his chin

- If this action results in pain at the back & pt unable to do so, it is said to be the client has neck stiffness

Cont'd

b. Kerning's sign

- While a client on supine position flex the hip to 90' angle and and try to extend the knee passively
- If this action results pain in the hamstrings & resistance to further extension
- Should be present bilaterally to support the meningitis diagnosis

Cont'd

Kernig's Sign of Meningitis:

Kernig sign: flex patients hip to a 90° angle and then attempting passively straighten the leg at the knee produces pain in the hamstrings and resistance to further extension. Should present bilaterally to support the meningitis diagnosis.

Cont'd

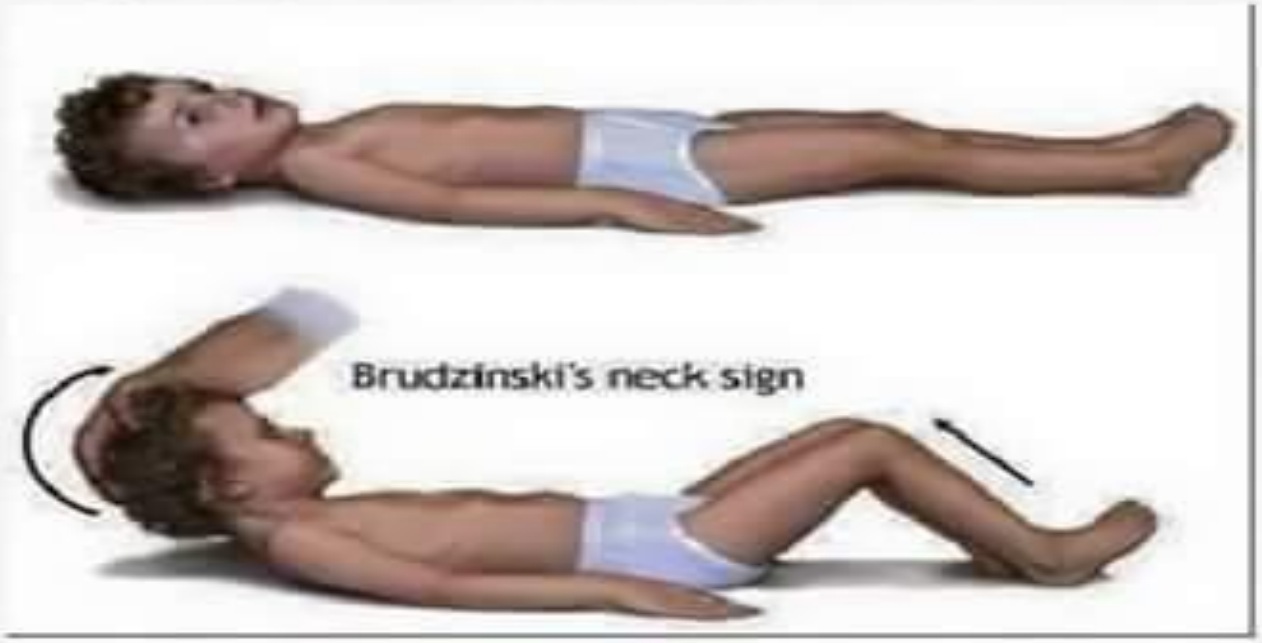
c. Brudzinski's sign

- **While a client on supine position if the pt hips & knees flex automatically when the examiner flexes the pt's neck**

Cont'd

Brudzinski Sign of Meningitis:

- **Brudzinski sign:** is positive if the patients hips and knees flex automatically when the examiner flexes the patients neck while the patient is supine.



Assessment of sensory function

- **Assess the client's for sensation acuity**
- **ex:**
  - **Tactile sensibility**
  - **Test for pain**
  - **Temperature sensation**
  - **Taste acuity**

Thank You